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### BONE DENSITY QUESTIONNAIRE

Patient Name \_\_\_\_\_ X-ray # \_\_\_\_\_  
Attending Doctor \_\_\_\_\_ Date \_\_\_\_\_

Are you left or right handed? Right \_\_\_\_\_ Left \_\_\_\_\_ Forearm measurement \_\_\_\_\_

Do you have a history of Osteoporosis? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have curvature of the spine? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had any type of fracture (spine, hip, wrist)? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have hip, wrist, joint, upper or lower mid back pain? Yes \_\_\_\_\_ No \_\_\_\_\_

Have your ovaries or uterus been removed surgically? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you postmenopausal? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, at what age? \_\_\_\_\_

Are you taking hormone therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you take large doses of vitamin D and/or calcium? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you take anticonvulsant therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a history of cancer? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, are you taking chemotherapy? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a history of renal disease? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have rheumatoid arthritis? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have an abnormal thyroid condition? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you taking steroid treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a history of alcohol or tobacco abuse? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you spent long periods confined to bed? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had any nuclear medicine studies of x-rays that required contrast (dye) or barium in the last 10 days? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you lost more than 2" of height since high school? Yes \_\_\_\_\_ No \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_